



## SOUTH DAKOTA BOARD OF NURSING SOUTH DAKOTA DEPARTMENT OF HEALTH

[www.state.sd.us/doh/nursing](http://www.state.sd.us/doh/nursing)

### RN & LPN NURSE LICENSURE BY ENDORSEMENT

South Dakota joined the [Nurse Licensure Compact](#) January 1, 2001. Therefore, if your primary state of residence (where you hold a driver's license, pay taxes, and/or vote) is also a [Compact State](#), you are not eligible for RN nor LPN licensure in South Dakota. For more information, see [www.ncsbn.org](http://www.ncsbn.org).

Please follow instructions carefully to avoid delays in processing your application. You can expect that it will take 3-4 weeks before all forms are received by this Board office so that your application can be considered for approval. You may call Monday-Friday, 8am-5pm, or [email](#) to check the status of your application. Applications are maintained for one year; all fees are non-refundable.

#### **FOREIGN EDUCATED**

In January 1994, South Dakota Board of Nursing rescinded its policy of endorsement of foreign educated RNs on the basis of the CNATS exam. Foreign educated applicants for RN licensure by endorsement must provide one of the following:

1. State Board Test Pool Examination: minimum score of 350 in all subjects.
2. [NCLEX](#)-RN<sup>®</sup> paper and pencil exam: minimum score 1600 or a pass report (through NCLEX-RN<sup>®</sup> 294).
3. [NCLEX](#)-RN<sup>®</sup> Computerized Adaptive Test (CAT) with a pass report beginning April 1, 1994.

#### **APPLICATION AND FEES**

- Complete General Application [Form 1](#).
- Fee payment should be in the form of a money order or a cashier's check payable to South Dakota Board of Nursing. The fee for licensure is \$100. If a Temporary Permit is also desired, see [step 5](#) below.
- Criminal Background Check
  1. Pursuant to SDCL 36-9-97, [ARSD 20:48:03:01:01](#), and [ARSD 20:48:05:01](#), each applicant for initial licensure is required to submit a full set of fingerprints with completed application to obtain a state and federal criminal background check.
  2. If you download an application off of the website ([www.state.sd.us/doh/nursing](http://www.state.sd.us/doh/nursing)) and submit the completed application to the South Dakota Board of Nursing fingerprint cards will be mailed to you.
  3. The fingerprint cards you receive from the SDBON **must** be the cards you use for fingerprints, since specific agency data are pre-printed on them.
  4. Contact your local law enforcement agency for fingerprinting.
  5. Send to the SD Board of Nursing office your completed fingerprint cards and a separate check or money order for \$44 payable to: South Dakota Division of Criminal Investigation (DCI).
  6. Your application will not be processed and/or temporary license will **not** be issued until your completed application **and** fingerprint cards are received.
  7. You will **not** receive a permanent license until the fingerprint results from the Federal Bureau of Investigation (FBI) are received, approximately 1-2 weeks.
  8. Cards will be rejected if bent, folded, tampered with, stained, smeared, or stapled. If rejected, you will be notified to resubmit your cards.

## **VERIFICATION OF LICENSE**

- Complete Part I of [Form 2](#) and send it to the office of the [Board of Nursing](#) in the state in which you were originally licensed as an LPN or RN, depending on which licensure you are seeking in South Dakota. Most states charge a fee for verification of licensure; contact that Board to determine whether a fee should be submitted. The Board of Nursing from the state in which you were originally licensed will send the completed form to the South Dakota Board of Nursing.
- If your original state of licensure requires licensure verification through NURSUS, please use the form available at [www.nursys.com](http://www.nursys.com). You may use the same link to see a list of participating states.

## **VERIFICATION OF EMPLOYMENT**

- For an active status nursing license, you must provide verification of nursing employment or volunteer work of at least 140 hours in any 12-month period, or an accumulated 480 hours, within the preceding 6 years. If you are unable to provide verification, contact the [Board](#) concerning a Nurse Refresher Course.
- Complete the top portion of [Form 3](#) and send it to your employer(s) for verification.

## **REQUEST FOR TRANSCRIPT**

Complete [Form 4](#) and send it to the Office of Registrar of the nursing education program which prepared you for initial licensure. An official transcript, not a copy, is required. There is often a charge to send a transcript; contact the Registrar Office to determine the appropriate fee to enclose with Form 4.

## **TEMPORARY PERMIT APPLICATION**

A Temporary Permit is required before you can begin orientation at your place of employment, or to practice nursing while awaiting licensure. The Temporary Permit is issued for one 90-day period and is not renewable. All fees are non-refundable. A Temporary Permit may be issued upon receipt of all of the following:

[Form 1](#): Application for Licensure by Endorsement with \$100 fee

[Form 3](#): Verification of Employment

[Form 5](#): Temporary Permit Application with \$25 fee

Photocopy of a current LPN or RN license bearing an expiration date

The criminal background check must also be completed before a Temporary Permit can be issued.



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## SOUTH DAKOTA DEPARTMENT OF HEALTH

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APPLICATION FOR LICENSURE BY ENDORSEMENT: FORM 1 - PG 1 OF 2

**All information on this form is to be completed by the Applicant.  
Please type or print in black ink. Note: Fees are non-refundable.**

I. DEMOGRAPHIC DATA						
CURRENT LICENSURE:	<b>LPN</b>	<b>RN</b>	<b>CRNA</b>	<b>CNP</b>	<b>CNM</b>	<b>CNS</b>
NAME: _____						
	First	Middle	Maiden	Last	Other(s):	
PRESENT ADDRESS: _____						
	Street or PO Box		City	State	Zip	
MAILING ADDRESS: _____						
	Street or PO Box		City	State	Zip	
HOME TELEPHONE: _____		OTHER TELEPHONE: _____		EMAIL: _____		
DATE OF BIRTH: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female		US CITIZEN: <input type="checkbox"/> Yes <input type="checkbox"/> No		SS# _____	
<input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other: _____						
II. PRELIMINARY EDUCATION						
	INSTITUTION NAME & LOCATION		DATES ATTENDED	YEAR OF GRADUATION	DEGREE GRANTED	
HIGH SCHOOL OR EQUIVALENT					<input type="checkbox"/> Diploma	
					<input type="checkbox"/> GED	
COLLEGE OR UNIVERSITY (NON-NURSING)						
III. PROFESSIONAL EDUCATION						
	INSTITUTION NAME & LOCATION		DATES ATTENDED	YEAR OF GRADUATION	DEGREE GRANTED	
BASIC PROGRAM IN NURSING						
ADDITIONAL NURSING EDUCATION						
ADDITIONAL NURSING EDUCATION						
IV. LICENSURE HISTORY						
STATE	LICENSURE		LICENSE #	YEAR ISSUED	EXPIRATION DATE	
ORIGINAL STATE:	<input type="checkbox"/> RN	<input type="checkbox"/> LPN				
OTHER STATE:	<input type="checkbox"/> RN	<input type="checkbox"/> LPN				
OTHER STATE:	<input type="checkbox"/> RN	<input type="checkbox"/> LPN				
OTHER STATE:	<input type="checkbox"/> RN	<input type="checkbox"/> LPN				

**V. DISCIPLINARY INFORMATION**

1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? <b>If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and All communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.	Is there any pending criminal prosecution against you which would constitute a felony?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9.	Do you currently owe child support arrearages in the sum of \$1,000 or more?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.**

**VI. EMPLOYMENT**

List your last six years of nursing employment. If you have not worked in nursing, please explain.

DATES OF EMPLOYMENT	INSTITUTION	CITY/STATE
FROM: TO:		
FROM: TO:		
FROM: TO:		
FROM: TO:		

**VII. DECLARATION OF PRIMARY STATE OF RESIDENCE – AND - AFFIDAVIT**

☐ I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is: \_\_\_\_\_ . This is my "home state" under the [Nurse Licensure Compact](#) and is my "declared fixed permanent and principal home for legal purposes."

- OR -

☐ I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer: \_\_\_\_\_

I further declare and affirm under penalties of perjury that this application for nurse licensure in South Dakota has been examined by me and, to the best of my knowledge and belief, is in all things true and correct.

\_\_\_\_\_  
APPLICANT SIGNATURE

\_\_\_\_\_  
DATE



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VERIFICATION OF LICENSE: FORM 2 - PG 1 OF 2

Complete Part I, then forward this form to the Board of Nursing in the state where you were originally licensed. Most states charge a fee for verification of licensure; to save processing time, contact that state Board to determine the appropriate fee to enclose with this form.

**PART I: TO BE COMPLETED BY APPLICANT; FORWARD TO ORIGINAL STATE OF LICENSURE**

NAME: _____					
First	Middle	Maiden	Last	Other(s):	
ADDRESS: _____					
Street or PO Box		City	State	Zip	
HOME TELEPHONE: _____		OTHER TELEPHONE: _____		EMAIL: _____	
DATE OF BIRTH: _____			SS# _____		
NURSING EDUCATION PROGRAM:	Institution: _____			Degree Granted: _____	
	Location: _____			Date of Completion: _____	
NAME AS IT APPEARS ON ORIGINAL LICENSE: _____					
STATE	TYPE		LICENSE #	ISSUE DATE	EXPIRATION DATE
ORIGINAL STATE OF LICENSURE:	<input type="checkbox"/> RN	<input type="checkbox"/> LP/VN			
CURRENT STATE OF LICENSURE:	<input type="checkbox"/> RN	<input type="checkbox"/> LP/VN			
OTHER STATE:	<input type="checkbox"/> RN	<input type="checkbox"/> LP/VN			
OTHER STATE:	<input type="checkbox"/> RN	<input type="checkbox"/> LP/VN			
OTHER STATE:	<input type="checkbox"/> RN	<input type="checkbox"/> LP/VN			
OTHER STATE:	<input type="checkbox"/> RN	<input type="checkbox"/> LP/VN			
<p>I authorize the _____ Board of Nursing to furnish to the South Dakota Board of Nursing the information requested on page 2 of this form.</p> <p>SIGNATURE: _____ DATE: _____</p>					

**VERIFICATION OF LICENSE: FORM 2 - PG 2 OF 2**

<b>PART II: TO BE COMPLETED BY ORIGINAL STATE OF LICENSURE AND FORWARDED TO THE SOUTH DAKOTA BOARD OF NURSING</b>			
THIS IS TO CERTIFY THAT (APPLICANT NAME):			
WAS ISSUED LICENSE #		TYPE: <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Practical/Vocational Nursing	
DATE ISSUED:	EXPIRATION DATE:		
LICENSED BY: <input type="checkbox"/> Examination <input type="checkbox"/> Endorsement <input type="checkbox"/> Waiver			
CURRENT STATUS: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed			
HAS THE LICENSE EVER BEEN ENCUMBERED (DENIED, REVOKED, SUSPENDED, SURRENDERED, LIMITED, PLACED ON PROBATION)? <input type="checkbox"/> YES <input type="checkbox"/> NO			

IS DISCIPLINARY ACTION PENDING?   ☐ YES    ☐ NO    If "YES", please provide explanation:

GRADUATED FROM: <input type="checkbox"/> 10 <sup>th</sup> Grade <input type="checkbox"/> High School <input type="checkbox"/> High School Equivalency (GED)				
NURSING EDUCATION PROGRAM COMPLETED:	INSTITUTION:		TYPE OF PROGRAM	
	LOCATION:		DATE GRADUATED:	
			<input type="checkbox"/> DIP	<input type="checkbox"/> LPN
			<input type="checkbox"/> AD	<input type="checkbox"/> Other:
		<input type="checkbox"/> BSN		

STATE BOARD TEST POOL EXAMINATION							NCLEX	
REGISTERED NURSE						LPN/VN	RN	LPN
TEST	Medical Nursing	Psychiatric Nursing	Obstetric Nursing	Surgical Nursing	Nursing of Children			
SCORE								
SERIES/ FORM #								

**SEAL**

SIGNATURE \_\_\_\_\_

TITLE \_\_\_\_\_

STATE \_\_\_\_\_ DATE \_\_\_\_\_



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VERIFICATION OF EMPLOYMENT: FORM 3 - PG 1 OF 1

To obtain/retain active status license, the applicant must provide verification of employment in nursing within the previous six years of at least 140 hours in any 12-month period OR an accumulated 480 hours.

If you have not worked or volunteered the required number of hours in nursing and wish to obtain a license, contact the SD Board of Nursing for more information.

<b>APPLICANT: COMPLETE THIS SECTION AND FORWARD THE FORM TO YOUR EMPLOYER(S) OR FORMER EMPLOYER(S). THIS FORM MAY BE DUPLICATED FOR ADDITIONAL VERIFICATIONS. RETURN THE COMPLETED FORM(S) TO THE SOUTH DAKOTA BOARD OF NURSING.</b>					
NAME:	First	Middle	Maiden	Last	Other(s):
ADDRESS:	Street or PO Box		City	State	Zip
SS#					
<input type="checkbox"/> I have been employed/volunteered as a <div style="display: inline-block; vertical-align: middle; text-align: center;"> <input type="checkbox"/> RN <input type="checkbox"/> LPN         </div> within the last six years.					
<input type="checkbox"/> I have not been employed as a nurse within the past six years.					
I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for Licensure purposes.					
SIGNATURE OF APPLICANT			DATE		
<b>THIS SECTION TO BE COMPLETED BY EMPLOYER</b>					
The above-named individual was employed/volunteered as a nurse		From:		To:	
		Total hours worked in this period:			
I, the undersigned, declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above for purposes of licensure is true and correct.					
SIGNATURE OF AGENCY REPRESENTATIVE/TITLE			DATE		
NAME OF EMPLOYER:					
ADDRESS OF EMPLOYER:					
TELEPHONE:			EMAIL:		



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REQUEST FOR TRANSCRIPT: FORM 4 - PG 1 OF 1

<b>APPLICANT: PLEASE FILL OUT THE INFORMATION REQUESTED BELOW AND FORWARD THIS FORM TO THE OFFICE OF THE REGISTRAR FROM YOUR NURSING EDUCATION PROGRAM.</b>					
NAME:	FIRST	MIDDLE	MAIDEN	LAST	OTHER(S):
ADDRESS:	STREET OR PO BOX		CITY	STATE	ZIP
DATE OF GRADUATION:			SS#		
<p style="text-align: center;">I am requesting that an official transcript (must bear raised or color coded school seal) of my nursing education be attached to this request and forwarded to the South Dakota Board of Nursing for licensing purposes.</p>					
SIGNATURE OF NURSE APPLICANT			DATE		
<b>REGISTRAR: PLEASE ATTACH THIS FORM TO THE OFFICIAL NURSING TRANSCRIPT AND SEND TO THE SOUTH DAKOTA BOARD OF NURSING AT THE ADDRESS BELOW.</b>					





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TEMPORARY PERMIT BY ENDORSEMENT: FORM 5 - PG 1 OF 1

APPLICATION FOR:    ☐ RN    ☐ LPN

<b>APPLICANT: COMPLETE ALL QUESTIONS; INCOMPLETE APPLICATIONS WILL BE RETURNED.</b>				
<ul style="list-style-type: none"> <li>▪ TEMPORARY PERMITS ARE ISSUED FOR A PERIOD OF 90 DAYS, AND ARE NOT RENEWABLE.</li> <li>▪ SOUTH DAKOTA LAW PROHIBITS THE PRACTICE OF NURSING WITHOUT A VALID SOUTH DAKOTA LICENSE OR TEMPORARY PERMIT.</li> <li>▪ A TEMPORARY PERMIT OR VALID LICENSE IS REQUIRED BEFORE YOU BEGIN ORIENTATION AT YOUR PLACE OF EMPLOYMENT.</li> </ul>				
THIS APPLICATION MUST BE ACCOMPANIED BY ALL THREE:				
1. A photocopy of a current RN or LPN license with expiration date, from any U. S. state or territory 2. Form 1 – Application for Licensure by Endorsement 3. \$125 money order or cashier's check (\$100 fee for endorsement + \$25 fee for temporary permit)				
NAME: _____				
FIRST	MIDDLE	MAIDEN	LAST	OTHER(S):
ADDRESS: _____				
STREET OR PO BOX	CITY	STATE	ZIP	
SCHOOL OF NURSING:	Institution: _____			
	Location: _____			
<b>INDICATE WHICH LICENSURE EXAMINATION YOU HAVE WRITTEN:</b>				
<input type="checkbox"/> State Board Test Pool Exam (SBTPE) (Prior to July 1982)	State where exam was written: _____	Year exam was written: _____		
<input type="checkbox"/> National Council Licensure Exam (NCLEX®)	State where exam was written: _____	Year exam was written: _____		
<input type="checkbox"/> Other:	State where exam was written: _____	Year exam was written: _____		
I will be employed by (Institution): _____				
Address: _____				
I will begin employment on (date): _____				
The RN applicant for licensure by endorsement into South Dakota who has been issued a temporary permit is required to use the initials <b>“RN App”</b> (Registered Nurse Applicant). The LPN applicant for licensure by endorsement into South Dakota who has been issued a temporary permit is required to use the initials <b>“LPN App”</b> (Licensed Practical Nurse Applicant).				
I certify that all information provided on this application is true to the best of my knowledge and belief.				
SIGNATURE OF APPLICANT _____				DATE _____